Independent Evaluation of the New Jersey Department of Health and Senior Services Comprehensive Tobacco Control Program

Annual Update

CTCP
NEW JERSEY
Comprehensive Tobacco Control Program

Executive Summary

Prepared for

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EXECUTIVE SUMMARY

Since its inception in 2000, the Comprehensive Tobacco Control Program (CTCP) of the New Jersey Department of Health and Senior Services (DHSS) has incorporated the Centers for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Control Programs*,[1] which is modeled after states with successful tobacco control programs such as California and Massachusetts. The combined elements of this approach, detailed in the CTCP logic model (see Appendix), are designed to change the social norms around tobacco use. During 2001, the CTCP implemented a full range of statewide and local initiatives to reduce tobacco use. Detailed information on the state's program activities are found in the *New Jersey Comprehensive Tobacco Control Program 2001 Annual Report*.[2]

An important element of the CTCP is evaluation. Through evaluation activities, the CTCP gains valuable feedback and guidance to provide New Jersey with the most effective tobacco control agenda. This second evaluation report presents additional baseline measures of tobacco policies in New Jersey and provides the first comparative data on tobacco use among youth and adults. It is important to note any changes in estimates from these repeated measures should be interpreted with caution since trends cannot be inferred from what is currently only two points of data collection. The evaluation findings in this report identify areas of progress as well as challenges for the CTCP. The data in this report represent the time period from the program's inception, July 2000, through December 31, 2001. In the time taken to prepare the 2001 Annual Update, the CTCP continued to grow and expand. Thus it is important to consider that this report is reflective of only the first 18 months of the program. Any comparisons with previously reported data should be made with consideration of timelines. A summary of the key findings based on the CTCP's goals is presented below.

Decreasing Initiation of Tobacco Use Among Youth and Young Adults

According to *Healthy New Jersey 2010*, the state's comprehensive set of health objectives for this decade, the goal is to reduce the percent of middle school and high school students who use cigarettes to 10% and 20%, respectively, by 2010.[3] To reach the 2010 target, the CTCP has undertaken a number of initiatives to promote anti-tobacco messages and prevent youth from smoking.

Community and Youth Mobilization Against Tobacco

In November 2000, the CTCP launched a grassroots, youth-led movement entitled REBEL *(Reaching Everyone By Exposing Lies)* and the movement has grown steadily. Twenty county-based chapters of REBEL operate throughout New Jersey. By the end of 2001, approximately 1,000 youth were active members of REBEL and approximately 4,000 New Jersey youth endorsed the movement. REBEL chapters conducted more than 600 local activities throughout the state during 2001.

Media and Counter Marketing

Studies suggest that the most effective anti-tobacco program is one that combines an aggressive media campaign with community or school-based interventions.[4-6] Launched in February 2001, *Not For Sale* is the theme

of New Jersey's first anti-tobacco advertising campaign introduced to support the REBEL movement. The youth anti-tobacco media campaign is intended to influence attitudes towards smoking and in turn, to prevent smoking initiation and reduce consumption. During 2001, the CTCP placed 454 television spots and 3234 radio spots to promote *Not For Sale*. Additionally, advertising spots appeared in over 300 schools and 250 movie theaters throughout the state during 2001.

Exposure to Anti-tobacco Media

In 2001, CTCP youth-focused media messages *(Not for Sale)* were explicitly linked to the REBEL movement. Based on the 2001 New Jersey Youth Tobacco Survey (NJYTS), which was conducted between October and December 2001, one third of students - 34.1% in middle school and 31.5% in high school - reported hearing of REBEL. More than half (56.1%) reported seeing or hearing "Not for Sale" media campaign messages.

Minor Access to Tobacco

Restricting minors' access to tobacco is also an important tobacco control strategy in delaying initiation among youth and reducing tobacco consumption. New Jersey's Tobacco Age of Sale Enforcement (TASE) program, which aims to decrease the rate of illegal sales to minors, has consistently improved merchant compliance rates since 1994. As of October 1, 2001, 77.9%[i] of New Jersey's tobacco merchants were compliant with the TASE law. All states are required under the Federal Synar Amendment to increase merchant compliance to at least 80% by June 2003 or risk significant loss of federal block grant funding. The TASE program is making steady progress toward meeting the requirements of the Synar Amendment.

However, despite the consistent increase in merchant compliance, minors can still readily purchase cigarettes. The 2001 NJYTS found that 58.1% of current smokers in middle school and 65.4% of current smokers in high school reported not being refused a cigarette sale because of their age. These findings are unchanged since the 1999 NJYTS. A community needs only one noncompliant merchant for minors to gain access to tobacco.

Youth Initiation

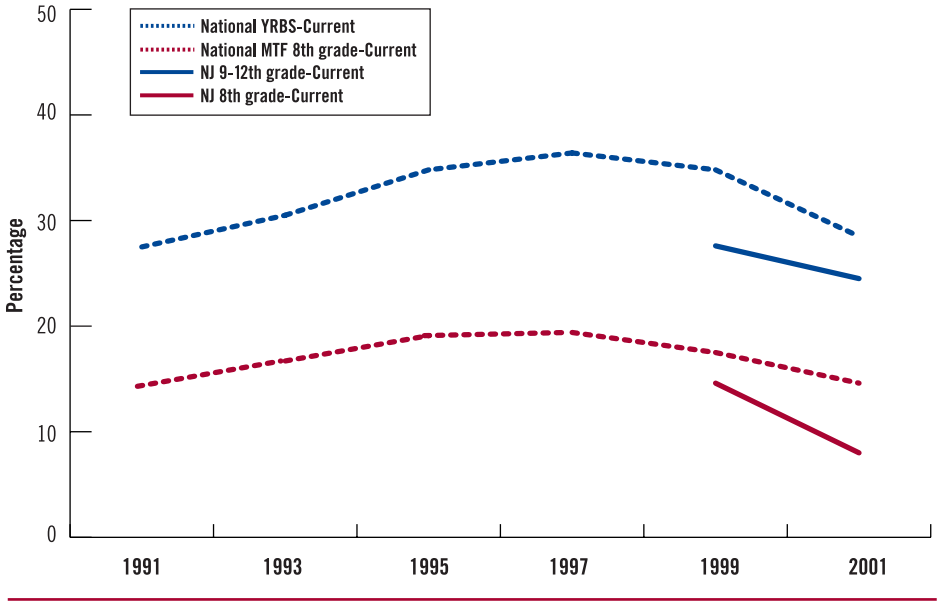
Preventing initiation is critical to reducing smoking consumption and prevalence. In the 2001 NJYTS, 45.9% of high school students reported ever having smoked a *whole cigarette*, representing a 7.6% decline in smoking initiation rates from 1999 (49.7%). Although preventing initiation is best, delaying the age of smoking onset can also affect smoking consumption and prevalence. The earlier youth begin smoking, the more cigarettes they are likely to smoke per day and the less likely they are to quit.[7] Based on NJYTS data, the proportion of high school students in New Jersey who started smoking prior to the age of 13 decreased significantly from 21.6% in 1999 to 17.0% in 2001, a 21% decline. Efforts to prevent youth from smoking or to encourage those who have just begun to experiment to quit can lead to marked changes in smoking prevalence among youth and adults.

[i] The merchant compliance rate of 77.9% is based on the weighted state sample.

Current Use of Tobacco Among Youth

In the second year of CTCP efforts, the 2001 NJYTS demonstrated substantial reductions in tobacco use among middle and high school students. Decreases in ever and current use (i.e., use in 30 days preceding the survey) of all tobacco products were documented for both middle and high school students since 1999.[8] Current cigarette smoking prevalence significantly declined among middle school students from 10.5% in 1999 to 6.1% in 2001, a 42% reduction. Current cigarette smoking prevalence among high school students fell from 27.6% in 1999 to 24.5% in 2001, an 11% decline. As previously mentioned, changes in prevalence estimates from 1999 to 2001 should be interpreted with caution and not unequivocally attributed to CTCP initiatives. With the CTCP still in its infancy, it is too early to determine whether these changes in prevalence will be sustained or what specifically influenced them.

Figure 1: Prevalence of current cigarette use among 8th grade and high school youth in the US and New Jersey - National YRBS, 1991-2001; MTF, 1991-2001; NJYTS, 1999-2001



Research has documented a decrease in youth smoking rates nationwide. As shown in Figure 1, cigarette smoking rates among high school students nationally declined by 18% from 1999 to 2001.[9] Comparing data from New Jersey to national data, the decline in smoking among high school students in New Jersey likely reflects nationwide trends in high school smoking prevalence. The decline in middle school smoking prevalence in New Jersey slightly exceeds the decline observed nationwide in the Monitoring the Future study.[10] Overall, the findings in New Jersey are consistent with national trends, where younger age groups are showing the biggest decline in tobacco use over the past few years. New Jersey is progressing in the right direction.

Cigarette Smoking Among Young Adults

Smoking among young adults (i.e., 18-24 year olds) in New Jersey has remained largely unchanged since 2000. In the 2001 New Jersey Adult Tobacco Survey (NJATS), which was conducted between September and December 2001, the prevalence of cigarette smoking continues to be higher among 18 to 24 year olds (27.2%) than any other age group. The high smoking rate among 18 to 24 year olds in New Jersey and nationwide is likely the result of both the aging of an adolescent cohort with high smoking rates and targeted marketing by the tobacco industry. [9,11] Despite having the highest smoking prevalence among all age groups, 18 to 24 year olds underutilized New Jersey's quit services relative to other age groups in 2001.

College campuses provide an excellent opportunity to reach 18 to 24 year olds. Students who live in smoke-free dorms are 40% less likely to take up smoking than those in unrestricted housing.[12] Only 27% of US colleges prohibit smoking in students' dormitories and 40% of colleges do not offer smoking cessation programs to help students quit.[13] In October 2001, DHSS health officials issued a call-to-action to encourage college presidents to protect students from ETS exposure. Shortly thereafter, the CTCP distributed the "Get Off Your Butts" information kits for colleges to encourage students to quit smoking and increase students' awareness of New Jersey's Quit services.

Increasing the Number of Tobacco Users Who Initiate Cessation

In 2001, 22.1% of New Jerseyans were current cigarette smokers. The CTCP's objective to reduce the prevalence of adults who are current cigarette smokers to 17.3% by June 30, 2003 is unattainable through decreases in smoking initiation alone. Reaching this target will require a substantial increase in the rate of smoking cessation. The majority of adult and adolescent smokers want to quit smoking. Helping smokers quit presents the best chance for short-term reductions in tobacco-related morbidity and mortality.

Nicotine Dependence Treatment Services

New Jersey is unique in providing smokers with three types of free or low-cost treatment options. Two of the services, New Jersey Quitnet, an online resource that provides comprehensive support for those trying to quit, and New Jersey Quitline, a toll-free telephone-based service that provides one-on-one smoking cessation counseling, were launched in late October 2000. Additionally, 15 New Jersey Quitcenters were established throughout the state between December 2000 and March 2002 to offer individual and group counseling as well as nicotine replacement therapy.

Media and Marketing

In September 2001, the CTCP launched a new series of quit ads ("Things Telling You") and added television advertising to the media mix for promotion of New Jersey Quitline and Quitnet. In total, CTCP purchased 992 television spots, 8064 radio spots, and various newspaper and bus placements to promote its cessation services during 2001. In addition to other advertising and promotional activities, 19,000 cessation kits (a.k.a. "black boxes") were distributed during 2001 to healthcare providers to educate and encourage referrals to DHSS Quit services.

Awareness of Promotional Efforts

Despite these efforts, few New Jerseyans were able to confirm awareness of a Quit services advertisement. Of adults able to confirm awareness of *any* anti-tobacco advertisement on the NJATS, only 7.5% identified one of the state's Quit services ads. However, data from CTCP Quit services suggest media efforts can impact utilization. For example, after television advertising began in September 2001, 50% of New Jersey Quitline users during the last quarter of 2001 reported television or radio as how they had heard of the service. Registrant data for New Jersey's Quitline and Quitnet suggest that television exposure increased contacts during and immediately following the two-month television run, underscoring the importance of television advertising.

Utilization of Quit Services

By the end of 2001, New Jersey Quitnet reported over 266,000 visits to the website and 4500 New Jerseyans registered as site users to help them with their quit attempts. In addition, 2750 smokers enrolled in New Jersey Quitline for telephone cessation counseling and 1120 smokers sought in-depth smoking cessation counseling through the New Jersey Quitcenters.

While consistent growth in Quit services utilization is encouraging, the overall rate of utilization remains extremely low. As of December 2001, after Quit services were in place for slightly more than a year, less than 1% of New Jersey smokers have accessed the state's free and low cost Quit services. However, heavy radio and television promotion of the Quit services did not begin until fall 2001. Now that a full range of New Jersey Quit services have been implemented, the CTCP must work to significantly improve awareness and utilization of its services.

Physician Counseling and Referral

Visiting a physician in the last year did not guarantee that a tobacco user would be identified or, subsequently, advised to quit or referred to New Jersey Quit services. Based on the 2001 NJATS, two-thirds of all adults who saw a physician in the past 12 months were asked about their smoking status. This is consistent with national data indicating that physicians identified patients' smoking status at 67% of all visits and this proportion has not increased over time.[14] Determining smoking status is a critical precursor to providing cessation counseling or referrals.

However, the 2001 NJATS found that among physicians that did identify smokers, a good proportion advised smokers to quit (63.0%) and some recommended various forms of assistance to their patients. Despite the CTCP having distributed thousands of "black boxes" or cessation kits to New Jersey's health care providers, smokers from the 2001 NJATS reported low rates of physician referral to the state's Quit services (< 9% referred to at least one of the Quit services). Physicians and other health care providers are critical to the success of CTCP's new cessation services. Limited tobacco control funds can be maximized by utilizing available evidence-based clinician materials and methods.[15,16] Adapting these tools for New Jersey would allow the CTCP to take advantage of existing knowledge and allow the program to concentrate on diffusing their message to those in a position to refer smokers.

Quit Attempts and Successes

In 2001, nearly two-thirds of current and previous year smokers (61.6%) in New Jersey reported making a serious quit attempt in the 12 months preceding the NJATS, but less than one out of ten adult smokers (9.2%) were successful in quitting during this time period. This cessation rate is consistent with findings in Massachusetts.[17] While adult smokers in New Jersey were *no* more successful at quitting than last year (10.8%), the percent of smokers attempting to quit significantly increased in 2001 compared to 2000 (55.7%), a 10.6% increase. Smokers take an average of three to four quit attempts before they are successful.[18]

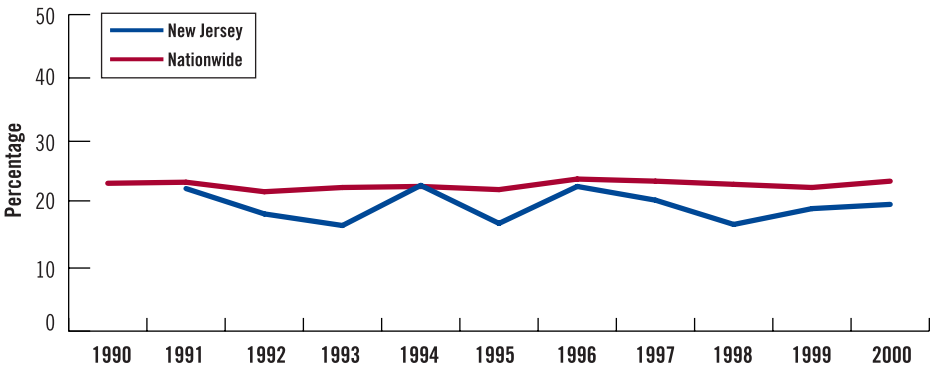
As discussed below, the events of September 11th may be associated with smoking relapse and therefore, could provide some explanation for the lack of improvement in adult cessation rates. It is possible that a number of smokers in New Jersey had previously quit or were in some stage of quitting but relapsed as a result of these events.

Adult Cigarette Smoking

Overall, the 2001 adult cigarette smoking prevalence estimate (22.1%) did not significantly differ from 2000 (19.8%). However, a 47% increase in smoking prevalence was documented among adults aged 45 and older. Given that the 2001 NJATS was carried out from late September through December 2001, it is difficult to discuss these estimates without some mention of September 11th and the events that followed.

Nearly 700 New Jerseyans were lost in the terrorist attacks on September 11th. The degree or intensity of this impact is impossible to calculate. But combined with the added stressors of an economic recession, the threat of future terrorist attacks, environmental consequences, additional strains on an overburdened commuter system, and an anthrax investigation, we suspect that the events surrounding September 11th, to some degree, contributed to the change in tobacco use behavior among New Jersey adults. Although the research is limited, recent studies have suggested a sizeable increase in the levels of stress, depression, anxiety, and associated substance use, including tobacco use, after September 11th.[19-21] In New Jersey, 17% of current smokers reported they smoked more since the attacks; however, it is unknown how many former smokers may have relapsed.[22] Since older adults are more likely to be former smokers, having quit at an earlier age, it is plausible that this population was particularly vulnerable to relapse during this time.

Figure 2: Prevalence of current cigarette use among adults in the US and New Jersey -BRFSS, 1990-2000



New Jersey's adult smoking rate remains lower than most other states, currently ranking 14th lowest nationally. However, cigarette smoking rates were relatively static over the past decade, both in New Jersey and in the US overall (see Figure 2). Furthermore, a recent study which adjusted for demographic shifts (e.g., race and age) indicated that state trends during the 1990s for cigarette smoking were essentially unchanged in 32 states, including New Jersey, and actually increased in 14 states.[23]

Decreasing Exposure to ETS

Environmental tobacco smoke (ETS) represents a significant public health threat to both smokers and non-smokers. Reducing exposure to ETS protects nonsmokers, particularly children, but can also influence social norms and encourage smokers to quit. ETS causes 53,000 deaths each year among nonsmokers, including 1,600 in New Jersey.[24]

Community Mobilization

Since CTCP's inception, community partners have conducted numerous activities targeted at reducing ETS. During 2001, twelve hundred employers / workplaces / restaurants and 141 managers of public places were contacted by Communities Against Tobacco (CAT) coalitions about the adoption of smoke-free policies. The Local Information Network Communication System (LINCS) reported the adoption of over 140 new worksite tobacco control policies in 2001. Restaurants and bars are among the most common sources of involuntary ETS exposure after home and work. LINCS reached out to 6300 restaurants to promote the adoption of smoke-free policies and conducted 230 meetings / seminars on smoke-free dining for restaurant owners.

Attitudes Toward Smoke-Free Policies

According to the 2001 New Jersey Eating and Drinking Establishment Tobacco Survey (NJEDTS), which was conducted between September and October 2001, most restaurants and bars with smoke-free policies either felt their policy was good for business (60.9%) or made no difference to their business (27.8%). Owners and managers of successful smoke-free establishments can support efforts to educate other restaurant / bar owners and provide convincing testimonials about the benefits of becoming smoke-free. Based on the 2001 NJATS, three-quarters of all adults (76.2%) preferred to sit in the nonsmoking section of a restaurant. Even among current smokers, 32.1% preferred being seated in a nonsmoking section and 30.0% had no preference. The 2001 NJATS also found widespread public support, even among smokers, for complete smoking bans in day care centers and schools. Additionally, the proportion of *smokers* who favored a smoking ban in indoor work areas significantly increased from 37.6% in 2000 to 46.1% in 2001, a 22.6% increase.

Policies Protecting New Jerseyans From ETS

On August 27, 2001, legislation that expanded the statutory prohibition on smoking in school buildings to school grounds was signed into law (NJSA 26:3D-17b). However, only a 100% tobacco-free policy would prohibit the use of all tobacco products by everyone (i.e., students, faculty, and visitors), in all locations (i.e., indoors, on school grounds, in school vehicles, and at school sponsored events), 24 hours a day. Based on the 2002 New Jersey School Health Education Profiles (NJSHEP), 42% of schools serving grades 6 to 12 had a 100% tobacco free policy that prohibited the use of all tobacco products by everyone in all locations 24 hours a day. This represents an increase from 2000 where one out of three schools (32.6%) had a 100% tobacco free policy. With eight years remaining, New Jersey is already halfway to reaching the Healthy People 2010 target of making *every* school tobacco-free.

According to the 2001 New Jersey Workplace Tobacco Survey (NJWTS), which was conducted between July and October 2001, 88.4% of all workplaces reported having a smoke-free policy. New Jersey law requires private employers with 50 or more employees to establish written rules to protect employees from ETS (NJSA 26:3D-23-25). In 2001, of workplaces with 50 or more employees, 77.9% reported having a written policy that prohibited smoking or limited use to designated areas. However, a policy does not imply enforcement.

Based the 2001 NJEDTS, approximately a third (36.2%) of restaurants and bars were smoke-free (i.e., a total ban on smoking indoors). Over a third of restaurants (37.3%) provided some accommodations for nonsmokers and 26.5% lacked any smoking restrictions. According to LINCS reports, 654 restaurants in the state became smoke-free during 2001. New Jersey made steady progress toward increasing the number of restaurants and bars with smoke-free policies, mainly due to its dedicated community partners.

Exposure to ETS

The 2001 NJYTS found that 52.1% of middle school students and 69.4% of high school students reported being exposed to ETS in either rooms or cars in the seven days preceding the survey. Furthermore, 42.9% of students reported living with someone who smoked cigarettes. Data show that adolescents who live with a current smoker are more likely to be smokers themselves.[25] Although self-reported ETS exposure among middle school students significantly declined by 13.8% from 1999 to 2001, self-reported ETS exposure among high school students and the proportion of students who lived with someone who smoked remained largely unchanged.

Based on the 2001 NJATS, roughly a quarter of adults (23.2%) reported someone smoked inside their homes during the 30 days preceding the survey. One in five households with children (19.7%) reported someone smoking inside their home in the past 30 days. There was no change in the proportion of adults reporting household ETS exposure from 2000 to 2001.

Decreasing the Acceptance of Tobacco

Effective tobacco control initiatives rarely address only one CTCP goal. The previously discussed program goals of preventing youth initiation, increasing cessation, and reducing ETS collectively contribute to changing the social norms around tobacco use. Not yet discussed are CTCP mass media and public relations, potentially powerful strategies to further shift social norms.

Exposure to Tobacco Control Messages

Based on the 2001 NJATS, 65.8% of adults reported having recently seen an anti-tobacco ad and 26.5% of adults were able to confirm exposure by accurately describing an advertisement. Of adults who were able to confirm awareness of an ad on the 2001 NJATS, 16.1% identified a CTCP ad. Specifically, 7.5% identified one of the state's Quit services ads and 3.8% identified a *Not for Sale* / REBEL ad.[ii] Some respondents (4.8%) identified the "Don't Get Sucked In" billboard ads placed as early as May 1999.

Newspaper Coverage of Tobacco

Content analysis of newspaper clippings showed a link between strategic public relations and press coverage, particularly for statewide efforts with great public appeal. Overall, 29.2% of tobacco-related clippings in a 16-month period ending December 2001, were specific to CTCP programs. Of articles about a CTCP program, 68% of all items and 91.0% of items on the Quit services contained contact information, which

[ii] The target audience for *Not for Sale* / REBEL advertisements is youth, not adults.

is essential for promoting utilization of services. Local efforts, such as CAT and REBEL programs, seem to have received less frequent coverage than other tobacco-related issues in New Jersey, suggesting a need for additional emphasis and training on media relations and media advocacy.

CTCP Benchmarks

Figure 3 presents expected outcomes after a sufficiently funded tobacco control program is applied effectively over several years. The CTCP has made steady progress towards short-term outcomes. While it is still too early to demonstrate longer outcomes such as reductions in tobacco-related disease and associated health care costs, the CTCP is beginning to document progress on some intermediate as well as long-term outcomes in only its first 18 months of operation. The CTCP needs to maintain its commitment to preventing

Figure 3: NJCTCP Progress Toward Suggested Tobacco Control Outcomes as of December 2001

Tobacco Control Outcomes and Timeline	Status*
Short Term Outcomes (< 12 months after the start of the program)	
Increase public awareness of tobacco control program	Steady progress
Increase initiation of nicotine treatment programs by adults and youth	Steady progress
Increase anti-tobacco media coverage	Steady progress
Increase number of smoking bans, ordinances, and policies	Steady progress
Intermediate Outcomes (1–2.5 years after the start of the program)	
Increases in the establishment of public nonsmoking environments	Steady progress
Decreases in cigarette sales to minors	Limited progress
Increases in knowledge of/attitudes toward key media messages	Limited progress
Decreases in the consumption of tobacco products	Limited progress
Long-Term Outcomes (2.5–5 years after the start of the program)	
Decreased percentage of adults smoking	Progress not yet documented
Decreased percentage of youth smoking	Steady progress
Decreased exposure to secondhand smoke	Limited progress
Longer Outcomes (10 or more years after the start of the program)	
Reduced number of tobacco-related cancers	Progress not yet documented
Reduced number of heart attacks and strokes	Progress not yet documented
Reduced health care costs related to tobacco combination	Progress not yet documented

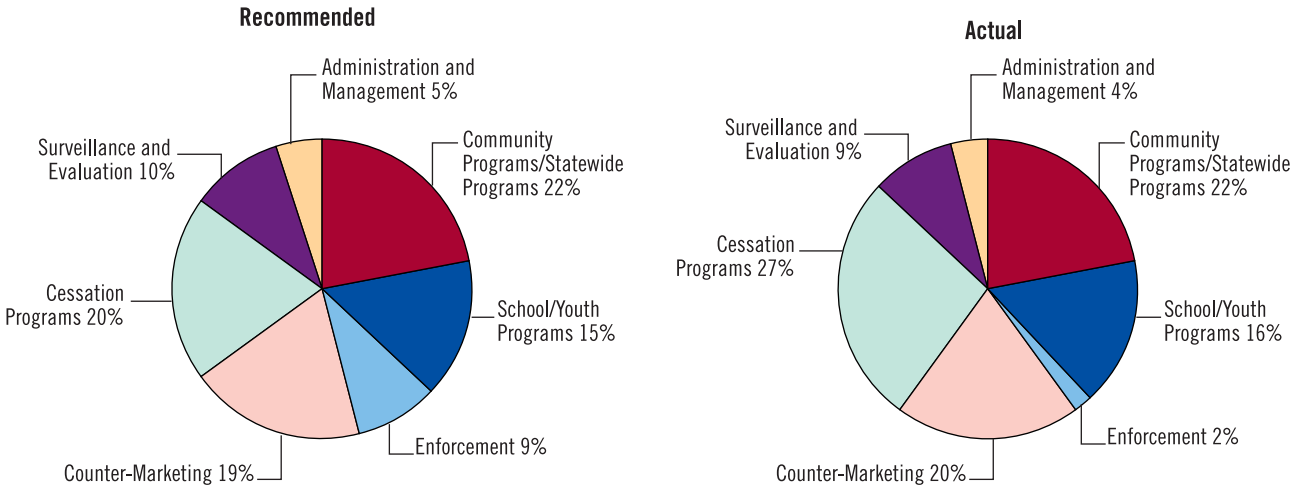
Adapted From: *NJCTCP Logic Model & CDC-Office on Smoking and Health, Investing in Tobacco Control: A Guide for State Decisionmakers, February 2001*

** Based on data from July 2000 to December 2001, steady progress denotes all outcome indicators show growth or improvement; limited progress reflects conflicting or limited improvement as shown by outcome indicators.*

tobacco use among young people through effective prevention and cessation programs for youth and young adults, reducing tobacco use among adults by promoting and increasing access to Quit services, and increasing the number of smoke-free environments. New Jersey can only see consistent reductions in smoking prevalence over time given adequate and sustained funding as recommended by CDC's *Best Practices*.

Figure 4 depicts Best Practices' recommended budget distribution for New Jersey based on suggested program elements and actual funding distribution for fiscal year 2001-2002.[iii] The distribution of CTCP funds is mostly consistent with Best Practices' recommendations. Cessation efforts are particularly well supported. The proportion of funding allotted towards administration and management is near the recommended level; however, given the magnitude of the program, the CTCP may benefit from funding administration and management at 5% of the overall budget. Additionally, considering the importance of reaching the Synar benchmark of 80% retailer compliance with age of sale laws by 2003, additional resources should be directed towards enforcement. It should be noted that CDC recommends that tobacco control in New Jersey be funded at a level of $45 to $121 million. In the 2001-2002 fiscal year, New Jersey's program budget was at 71% of the lowest estimate for funding at a total of $32 million.

Figure 4: *Best Practices'* recommended funding for tobacco control in New Jersey compared to FY01/02 actual funding for CTCP

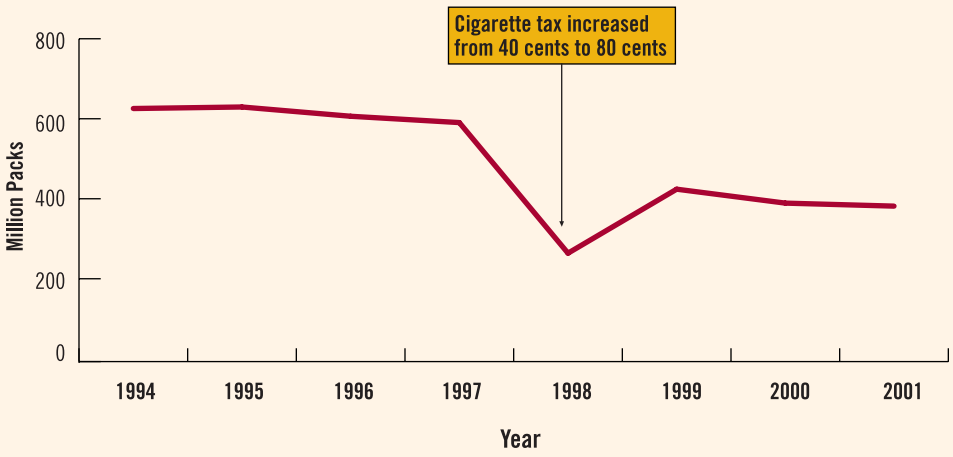


[iii] Chronic disease programs to reduce the burden of tobacco-caused diseases are not included. However, DHSS has funded a new initiative with the Cancer Institute of New Jersey for $20 million, which will include addressing this recommended element of *Best Practices*.

Emerging Issues

On June 30th, 2002, New Jersey passed a 70-cent tobacco tax increase giving the state one of the highest cigarette tax rates in the nation, tied with New York at $1.50. As a result, New Jersey was hailed as one of the nation's emerging leaders in tobacco prevention according to the Campaign for Tobacco Free Kids' mid-year update on funding for tobacco control released in July 2002.[26] The tobacco tax increase will facilitate CTCP's progress toward reducing cigarette consumption and smoking prevalence. In 1998, a significant decrease in sales, and likely consumption, was documented when the cigarette tax in New Jersey was increased from 40 cents to 80 cents.

Emerging Issues: Cigarette packs legally sold in New Jersey — NJ Department of Treasury, Division of Revenue, 1994-2001



Research shows that higher cigarette prices are associated with decreased rates of tobacco use, particularly among children, adolescents, and pregnant women.[27,28] In New Jersey, a cigarette tax increase of 70 cents is projected to prevent 61,200 youth from becoming future smokers and to prompt 46,000 adult smokers to quit.[29] The CTCP is equipped, via their Quit services, to assist New Jersey smokers who choose to free themselves from nicotine addiction and dependence.

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GLOSSARY

Abbreviations and Acronyms

ALF: The American Legacy Foundation is the national, independent public health foundation established by the 1998 Master Settlement Agreement. It is dedicated to reducing tobacco use in the United States through major initiatives reaching youth, women, and priority populations.

BRFSS: Behavioral Risk Factor Surveillance System is an ongoing nationwide surveillance system supported by the CDC and conducted in all 50 states.

CAT: Communities Against Tobacco is a network of local coalitions in each New Jersey county. These coalitions are joined together with a common mission to change or establish community norms, attitudes, and behaviors around tobacco use.

CATI: Computer-Assisted Telephone Interviewing is a system in which a telephone interviewer conducts an interview, using a computer and a computerized questionnaire.

CDC: Centers for Disease Control and Prevention is an agency of the US Department of Health and Human Services.

CTCP: Comprehensive Tobacco Control Program, launched in New Jersey in 2000, was created using MSA funds to help stop young people from smoking and help current smokers quit.

DHSS: Department of Health and Senior Services, State of New Jersey.

ETS: Environmental tobacco smoke is a mixture of the smoke given off by the burning end of a cigarette, pipe, or cigar and the smoke exhaled from the lungs of smokers.

LINCS: The Local Information Network Communication System is an electronic public health information system designed to enhance the identification and containment of diseases and hazardous conditions that threaten the public's health.

LSC: The Liberty Science Center, an interactive, hands-on science center, collaborated with DHSS to create a collection of three anti-tobacco programs that combine entertainment and education to reach New Jersey students in grades 4 to 12.

MSA: The Master Settlement Agreement was a landmark legal settlement between 46 states and the tobacco industry intended to compensate the states for health costs attributed to tobacco use.

MTF: Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults. The study is conducted at the Institute for Social Research at the University of Michigan.

NJ Quitnet: The New Jersey Quitnet (www.njquitnet.org) is a free online resource for smokers. The website offers peer support groups and trained counselors, 24 hours a day, as well as a quitting calendar, quitting tools and strategies, and a directory of local treatment options.

NJ Quitline: The New Jersey Quitline (1-866-NJSTOPS) is a toll-free telephone based service for smokers that offers one-on-one counseling in 26 languages.

NJ Quitcenters: The New Jersey Quitcenters offer smokers face-to-face counseling in a clinic setting. The 15 Quitcenters offer individual and group therapy as well as reduced-cost nicotine replacement therapy.

NJATS: The New Jersey Adult Tobacco Survey is a population-based survey designed to examine the tobacco behavior, knowledge, and attitudes of New Jersey adults.

NJEDTS: The New Jersey Eating and Drinking Establishment Tobacco Survey collects data on smoking policies in restaurants and bars.

NJGASP: The New Jersey Group Against Smoking Pollution works to secure smoke-free air for nonsmokers and ensure tobacco-free lives for children by helping to create local policy and legislation.

NJSHEP: The New Jersey School Health Education Profiles monitor characteristics of health education in middle schools and high schools.

NJWTS: The New Jersey Workplace Tobacco Survey collects data on workplace tobacco control policies.

NJYTS: The New Jersey Youth Tobacco Survey is a component of CDC's Youth Tobacco Surveillance and Evaluation System and monitors tobacco use behavior among middle and high school students.

N-O-T: Not-On-Tobacco is a quitting program designed specifically for teens developed by the American Lung Association, in collaboration with West Virginia University.

Not for Sale: "Not for Sale" is an advertising campaign intended to support the REBEL movement.

PEP: The Process Evaluation Project was designed to provide useful information and feedback to DHSS about the community-based components of the CTCP. The process evaluation relies on key informant interviews, site visits, and review of secondary data.

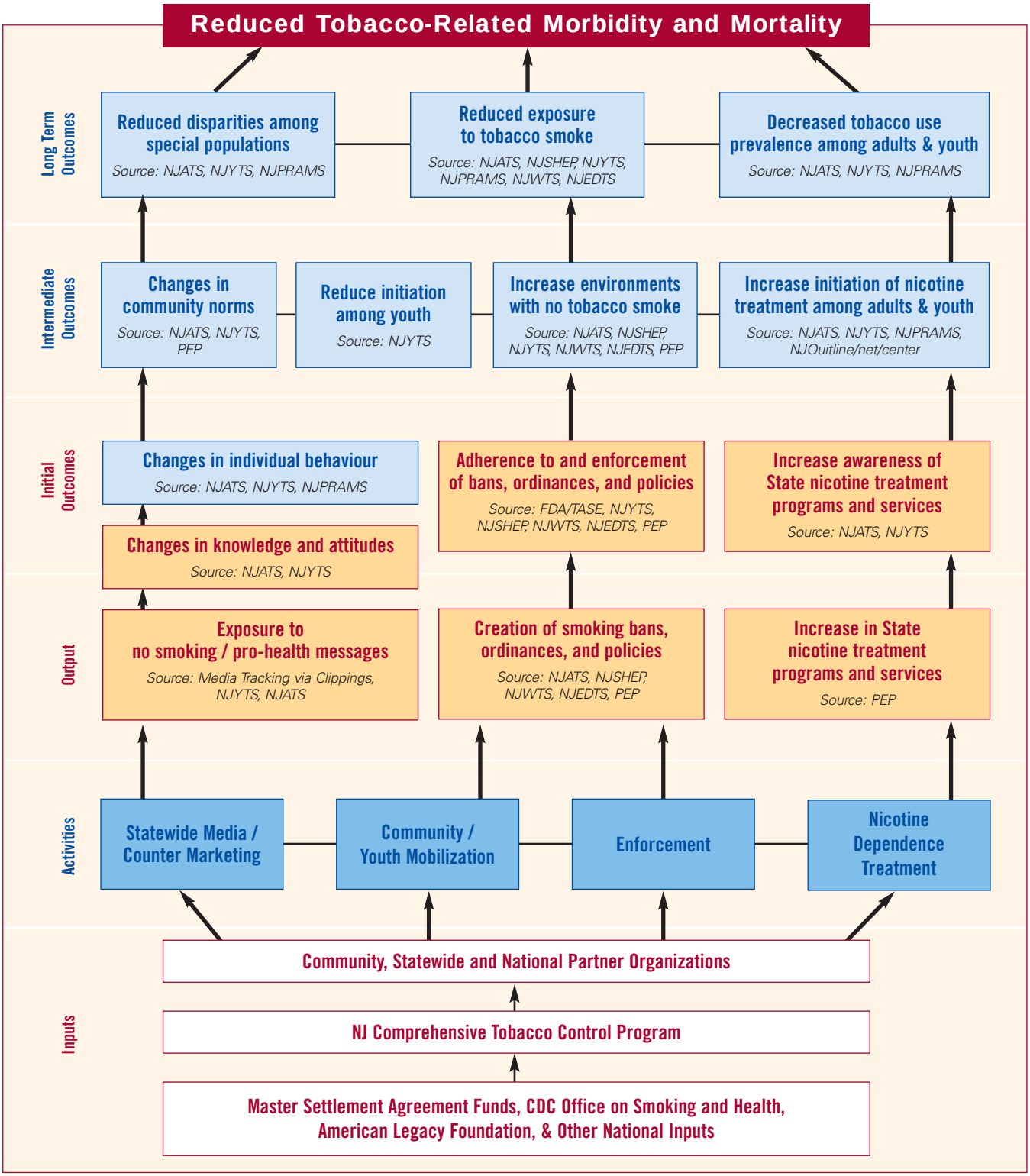
REBEL: Reaching Everyone By Exposing Lies is an initiative developed by and for teens in New Jersey to combat tobacco industry marketing tactics.

Synar Amendment: The Synar Amendment, named for the late Congressman Michael Synar, is a federal law that requires states to restrict and reduce youth access to tobacco products or risk loss of block grant funding for alcohol and drug programs.

TASE: Tobacco Age of Sale Enforcement includes merchant education and random unannounced compliance check inspections by DHSS staff or local health officers accompanied by underage youth.

UMDNJ: The University of Medicine & Dentistry of New Jersey is the state's university of the health sciences and includes eight schools on five campuses.

APPENDIX: NEW JERSEY COMPREHENSIVE TOBACCO CONTROL PROGRAM – LOGIC MODEL WITH EVALUATION DATA SOURCES



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CTCP
NEW JERSEY
Comprehensive Tobacco Control Program